UNITED STATES CIVIL SERVICE COMMISSION
BUREAU OF RETIREMENT AND INSURANCE
WASHINGTON 25, D.C.

ADDRESS REPLY TO "U.S. CIVIL SERVICE COMMISSION" AND REFER TO FILE AND DATE OF THIS LETTER

Date: July 1960

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STATISTICAL REPORTS

UTILIZATION DATA

Instructions

A. GENERAL

These instructions and the accompanying table formats relate to item C "Utilization" of Appendix C of your contract with the U. S. Civil Service Commission. In accordance with the requirements of this Appendix C, statistical data will be provided separately for active employees, retired employees, survivor annuitants, and family members. Plans offering two options will report separately for the high and low options, as well as for both options combined.

As is explained in the instructions sent to you with respect to item B Exposure, annuitants are active employees enrolled under the Federal Employees Health Benefits program who retire after its effective date and who are reported to the carrier on Standard Form 2810 as transferred from employee status to annuitant status.

1. Table Formats:- The accompanying table formats are intended as guides indicating (1) the data requested and the detail in which they are to be presented; and (2) the character of the data to be reported. This is to assure uniformity in reporting by different carriers.

The formats are not "forms" to be filled in. Each carrier may adjust them, if necessary, to fit his statistical procedures. However, they should be followed as closely as possible and may be used as "forms" if convenient.

2. Basis of Reporting:- Carriers with enrollments of less than 5,000 employees will report on all their claims.

Carriers with enrollments of 5,000 employees or more will report on the basis of a random sample of 10% of all claims.

The reports will show the actual findings of the sample. Thus, the totals shown will be the actual totals for the 10% sample. The Commission will prepare the estimates of total utilization based on the reported findings of the 10% sample.

A simple method of making certain that the data reflect a random sample is to include each 10th claim in the sample. Because of the different systems used by the various carriers it is not practical, at this time, for the Commission to

issue instructions with respect to the method of selecting this sample. However, in order to make it possible for the Commission to interpret the data properly, each carrier will submit a detailed statement explaining the manner by which the sample was selected.

3. Due Date of the Reports:- The reports will cover the contract year ending October 31 and are due within 60 days from that date, as required by Appendix C of the contract.

4. Source of the Data:- These data will be derived from the claims records of each carrier -- e.g., claims, supporting statements by hospitals and physicians, and "worksheets" used by the carriers.

B. EXPLANATION OF THE TABLES

Tables D.I through D.V are designed to reflect: (1) the utilization of medical services covered by the plans; (2) the medical expenses incurred by the covered employees and their dependents; and (3) the extent to which the insurance provided by the plans meets these expenses. While the general tabulation scheme is the same as that used for all other carriers participating in the FEHB program, these table formats have been designed to fit the benefit provisions of employee organization plans.

As already indicated, in accordance with the requirements of Appendix C, plans with a high and low option will report separately for each option, as well as for both options combined, as shown on each of the tables.

Tables D.I through D.IV will include only data on nonmaternity claims. Tables D.V-A and D.V-B deal with maternity cases only. Tables D.I (A, B, and C) summarize the plan's experience. Tables D.II through D.IV reflect the experience of certain categories of cases. While the same data are requested in these tables, Tables D.I (A, B, and C), D.II and D.III-B follow the same format. Similarly, Tables D.III-A and D.IV follow the same design.

Data on expenses incurred by the claimant and on benefits paid by the plan are to be reported in whole dollars rounded to the nearest dollar.

The term "dependent spouse, male" wherever used in these table formats means a male spouse covered under a family contract issued to a female employee, and includes both those covered as a "dependent husband" and those covered as a "non-dependent husband."

The tables require data for several different categories of patients. Basically, these are the categories:

A. Total, all categories
B. Active employees and their dependents, total

    1. Active employee, total
        a. Male
        b. Female

2. Dependents of active employees, total
   a. Spouse, total
      (1) Male
      (2) Female

   b. Children

C. Annuitants and their dependents, total

1. Employee and survivor annuitants
2. Dependents of employee and survivor annuitants.

These categories are shown in column 1 of Tables D.I-A, D.II, and D.IV. For the other tables data are requested only for major groupings of categories of patients -- as shown on each table. Subtables will be prepared for each of the groupings indicated on the table.

TABLE D.I-A. NONMATERNITY SERVICES: GENERAL SUMMARY

This table is designed to summarize the utilization of various health care services, the health care expenditures of the different categories of patients, and the amount of benefits paid by the plan toward these expenses. It is divided into 4 parts: (1) A summary for all types of cases; (2) A subtable for hospitalized cases not involving surgery; (3) A subtable for hospitalized cases involving surgery; and (4) A subtable for all other cases.

Carriers with plans offering two levels of benefits will show, separately for each of these parts, data for: (a) both options combined; (b) high option only; and (c) low option only. Part (1) will be the total of subtables (2), (3), and (4).

Data for (a) both options combined will be the sum of: (b) high option plus (c) low option.

For each category of patients show, below the designation of the category, in the appropriate columns: (1) the number of claimants and (2) the number of claims involving each of the types of services indicated; (3) the amount of expenditure incurred by the patients; and (4) the total amount of benefits paid by the plan.

Column 1 lists the different categories of patients. Column 2 is for the number of claimants. Columns 3 through 6 deal with hospital utilization and hospital expenses (exclusive of personal service expenses, e. g., telephone, television, barbering, etc.). Columns 7 through 12 deal with physician and related services and the expenses for such services. Column 13 is the total of all expenses (other than for personal services) incurred by the patient. Column 12 is for the total amount of benefits paid by the plan.

Column 1, Patient Category:

These include the various categories of enrollees and of their dependents covered under the plan. In accordance with the "Note" on the table insert "number" and "amount" under each category of patients (i.e., employee, total; employee, male; employee, female; etc.) as is indicated by lines 2 and 3 under line 1; and 5 and 6 under line 4.

Entries will be made only on "number" and "amount" lines.

Line 1:- Total for all patient categories--enrollees and dependents.

Line 2:- Total number of claimants, days hospitalized and claims for different types of services indicated.

The sum of line 5 + the "number" line to be inserted immediately below line 15.

No entry would be made in columns 4 through 7 and in columns 13 and 14.

Line 3:- Total amount of expenditures by all patients.

The sum of line 6 + the "amount" lines to be inserted below line 15.

No entry would be made in columns 2 and 3.

Line 4:- Active employees and their dependents combined.

Lines 5 - 6:- The total number of employees and their dependents filing claims; and the total amount of their expenses and of benefits paid. The sums of data for employees (the "number" and "amount" lines to be inserted immediately below line 7) plus data for dependents of employees (the "number" and "amount" lines to be inserted immediately below line 10).

Line 7:- All employees filing claims. The sum of line 8 + line 9.

Line 8:- Male employees.

Line 9:- Female employees.

Line 10:- All dependents of active employees. The sum of lines 11 + 14.

Line 11:- Sum of lines 12 + 13.

Line 12:- Male spouse of active employee, including both dependent and "non-dependent" husband of female employees.

Line 14:- Children of active employees.

Line 15:- All annuitants and their dependents. The sum of lines 16 + 17.

Line 16:- All employee annuitants and survivor annuitants.

Line 17:- All dependents of all annuitants.

Column 2, Number of Claimants:

The number of claimants (different individuals as distinguished from claims) in each of the categories in column 1.

Line 2:- Total number of claimants, all categories of enrollees and dependents: The sum of line 5 + the "number" line inserted immediately below line 15.

Line 3:- No entry.

Line 5:- Total number of active employees and of dependents of active employees filing claims. The sum of the "number" lines inserted, immediately below lines 7 and 10.

Line 6:- No entry.

Line 7:- All active employees filing claims. On the "number" line inserted immediately below this line enter the sum of the "number" lines inserted immediately below lines 8 and 9.

Lines 8 through 17:- The number of claimants in each of the categories shown in column 1, as explained above.

Column 3, Aggregate Number of Days of Hospitalization:

The total number of days spent in hospitals by the patients in each of the categories in column 1.

No entry will be made on the "amount" lines 3, 6, etc.

Line 2:- The total number of days for all claimants on line 2 of column 2.

The sum of line 5 + the "number" line inserted below line 15.

Line 5:- Number of hospital days for all active employees and all dependents of active employees.

The sum of the "number" lines inserted below line 7 and below line 10.

Line 7:- Number of hospital days for all active employees. On the "number" line inserted below line 7 enter the sum of the "number" lines inserted below line 8 and below line 9.

Lines 8 through 17:- Number of hospital days for all claimants in each of the categories shown in column 1, as explained above.

Column 4, Total Hospital Expenses:

This is the sum of column 5 + column 6.

No entry will be made on lines 2, 5, and on the "number" lines inserted (in column 1) below each of the categories and sub-categories of patients.

Column 5, Expenses for Hospital Room and Board:

On lines 3, 6, and on each of the "amount" lines inserted (in column 1) below the categories and sub-categories of patients enter the amount of expenses incurred for hospital room and board by the various categories and sub-categories of patients.

Column 6, Other Hospital Expenses:

This includes all hospital expenses other than for room and board. Excludes expenses for personal services.

Column 7, Physicians' and Other Expenses, Total Expenses:

This is the sum of columns 8 through 12.

No entry would be made on lines 2, 5, and on the "number" lines inserted (in column 1) below each of the categories and sub-categories of patients.

Column 8, Physician's Fees, Surgical Services:

This includes fees for surgical procedures, reduction of fractures, therapeutic x-ray series, etc., in or out of hospital.

On lines 2, 5, and each of the "number" lines inserted in column 1 show the number of claims for surgeons fees for each of the various categories and sub-categories of patients. On lines 3, 6, etc., show the amount of such fees.

Column 9, Physicians' Fees, Medical Services:

Physicians' fees for non-surgical services in or out of hospital. Exclude fees for such services as diagnostic x-rays, laboratory examinations, etc. These will be shown as "other related expenses" in column 12.

On lines 2, 5, etc., show the number of such services; on lines 3, 6, etc., show the amount of the fees.

Column 10, Related Expenses, Special Nursing:

Claims for expenses for nursing other than general nursing care provided by the hospital and included in its charge for room and board.

Show the number of claims for special nursing, and the amount of expense incurred by the patient on the appropriate lines.

Column 11, Related Expenses, Non-hospital Drugs:

Claims for drugs other than those provided while hospitalized.

Column 12, Other Related Expenses:

Include here all other related expenses for such services as: Ambulance, X-ray, laboratory, tests, etc.

Column 13, Grand Total Claimants Expenses:

Sum of column 4 + Column 7.

No entry would be made on lines 2, 5, and on the "number" lines inserted (in column 1) below each of the categories and sub-categories of patients.

Column 14, Grand Total, Benefits Paid by Plan:

This is the total of the amounts of benefits paid by the plan to the claimants in column 2 for each of the categories and sub-categories of patients in column 1.

No entry would be made on the "number" lines indicated in column 1.

TABLE D.I-B. NONMATERNITY SERVICES

State Summary.

Column 1, State:

The geographical location where the hospital and medical service was provided.

For each area, show totals for both options combined and for high and low options separately. Carriers with only one option will show the data on the "total" line.

Line 1:- The sum of lines 2 + 3, also of lines 4 + 5.

Line 2:- Total for high option. The sum "high option" under each of lines 4 + 5.

Line 3:- Total for low option.

Line 4:- The sum of lines 6 + 58.

Line 5:- Areas outside United States and Territories, and Dependencies.

Line 6:- The sum of lines 7 through 57.

Line 58:- Territories and Dependencies of the United States.

Column 2, Number of Claimants:

The number of claimants in each of the areas in column 1. Plans having only one option will show this on the "total" lines. Those having 2 options will show the total for both options, and the number for the high and low options separately.

Column 3, Hospitalization, Number of Claims:

The number of claims which involved hospital expense. Claims supplementary to a single period of hospitalization should be recorded as a single claim to the extent ascertainable and practicable.

On each "total" line enter the number of claims involving hospital expenses incurred in the areas specified in column 1. Plans providing 2 options will show this for each area for the high and low options separately.

Column 4, Hospitalization, Aggregate Number of Days:

The number of days of hospital care reported on the claims for each of the high and low options separately.

Column 5, Hospitalization, Total Expense:

The sum of columns 6 + 7.

Column 6, Hospital Room and Board Expense:

The amount of the hospital expenses incurred for room and board. For each of the areas in column 1, show the total for both options combined and for the high and low options separately.

Column 7, Other Hospital Expense:

The amount of claimed hospital expense other than room and board. Exclude expenses for personal services.

For each area, show the total for high and low options combined, and for each option separately.

Column 8, Physicians' and Other Expenses; Total:

The sum of columns 10 + 12 + 14.

Column 9, Physicians' Fees for Surgical Services; Number of Claimants:

The number of claimants submitting claims on surgeons' fees.

Show number for: (1) both options combined; (2) high option; and (3) low option.

Column 10, Physicians' Fees for Surgical Services; Amount:

The amount of surgeons' fees reported by claimants in the preceding column.

Column 11, Physicians' Medical Services; Number of Claimants:

The number of claimants submitting claims for physicians' fees for professional medical (non-surgical) services.

(DO NOT include expenses for supporting laboratory, and other diagnostic services. These are to be considered in Columns 13 and 14 "other related expenses.")

Column 12, Physicians' Medical Services; Amount:

The amount of expenses for physicians' fees for medical (non-surgical) personal professional services.

Column 13, Related Expenses; Number of Claimants:

The number of claimants submitting claims for related medical expenses not reported in preceding columns. Include expenses claimed for laboratory, X-ray and other diagnostic services, drugs, private nursing, special appliances, ambulance, etc.

Column 14, Related Expenses; Amount:

The total amount of expenses for "other related expenses" reported in column 13.

Column 15, Grand Total; Claimants' Expenses:

The total of columns 5 + 8.

Column 16, Grand Total; Benefits Paid by Plan:

The total amount of benefit payments made by carrier with respect to claims shown in the preceding columns.

TABLE D.I-C. NONMATERNITY SERVICES, SUMMARY BY AGE AND SEX

This table summarizes the experience of the plan with respect to categories of claimants in varying age groups. It is limited to enrollees only (active employees, employee annuitants, and survivor annuitants). It is in 3 parts: (1) a summary for all categories of claims; (2) a subtable for all active employees; and (3) a subtable for all annuitants. Data in part (1) will be the sum of data in parts 2 and 3.

Column 1 lists 9 different age groups. Column 2 is for the number of claimants in each of such groups. Columns 3 through 7 deal with hospitalization data; columns 8

through 14 with physicians' and other expenses; columns 15 and 16 with total expenses and benefits repsectively.

Column 1, Age and Sex:

Line 1:- Total for all ages; the sum of lines 2 + 3, also of lines 4 + 7 + 10, etc.

Line 2:- Total for all male claimants; the sum of lines 5 + 8 + 11, etc.

Line 3:- Total for all female claimants; the sum of lines 6 + 9 + 12, etc.

Line 4:- Total for all claimants under 19 years of age--the sum of lines 5 + 6.

Lines 5 and 6:- Claimants under age 19: Male and female, respectively.

Lines 7 through 27:- See above.

Column 2, Number of Claimants:

Number of enrollees filing claims in each of the age group (male, female) indicated in column 1.

Line 1:- Total, all ages. The sum of line 7 + line 16 in Table D.I-A, column 2.

Column 3, Number of Hospital Claims:

Number of claims of enrollees in each of the age groups (male, female) indicated in column 1.

Column 4, Aggregate Number of Hospital Days:

The number of hospital days of enrollees in the age groups in column 1.

Line 1:- Total, all ages: The sum of lines 7 + 16, in Table D.I-A, column 3.

Column 5, Total Hospital Expenses:

The sum of columns 6 + 7.

Line 1:- Total, all ages. The sum of lines 7 + 16 in Table D.I-A, column 4.

Column 6, Hospital Expenses for Room and Board:

Self-explanatory.

Column 7, Other Hospital Expenses:

Hospital expenses other than for room and board, excluding charges for personal services.

Column 8, Total Physicians' and Other Expenses:

The sum of columns 10 + 12 + 14.

Columns 9 - 10, Surgical Services, Number of Claimants; Amount:

Number of claimants submitting claims that include a charge for surgeons' services; amount of such claims.

Columns 11 - 12, Medical Services: Number of Claims; Amount:

Number of claimants submitting claims for physicians' non-surgical services, in or out of the hospital. (Exclude such services as diagnostic X-rays, laboratory tests, etc. The number and amount of such claims will be included in columns 13 and 14 as "other related expenses.")

Columns 13 - 14, Other Related Expenses: Number of Claimants; Amount:

Number of claimants submitting claims for expenses other than for physicians' services. Include claimants submitting claims for such services as diagnostic X-rays, laboratory tests, etc. Amount of such claims.

Column 15, Grand Total, Claimant's Expenses:

Total of columns 5 + 8.

Column 16, Grand Total, Benefits Paid by Plan:

Total amount of benefits paid by plan for claims reported in preceding columns.

Line 1:- This will be the total of lines 7 + 16 in column 14 of Table D.I-A.

TABLE D.II. DURATION OF HOSPITALIZATION

This table deals with hospitalized cases only. It is designed to show the lengths of hospital stay; and the nature, amount of incurred expenses; and amount of benefits for hospitalizations of varying periods. Subtables will show the same data for each of the patient categories indicated, as well as for each option.

Column 1, Number of Hospital Days:

For each of the lengths of stay specified, show: (1) the data for all cases; (2) for male patients; and (3) for female patients, as indicated for each of the first 3 class intervals and by the words "as above" which appear below each of the other classes.

Column 2, Number of Claimants:

Number of persons hospitalized for each of the "number of days" specified in column 1.

Line 1:- The sum of the entry for "male" + entry for "female." Also, the sum of line 2 in column 2 of Table D.I-A,2 and of Table D.I.A,3.

Column 3, Hospitalization, Aggregate Number of Days:

On each line, show the total number of days for all patients (total, male, female) hospitalized for the "number of days" specified in column 1.

Line 1:- Identical with line 2 of column 3 of Table D.I.-A,1.

Column 4, Hospitalization, Total Expenses:

The sum of columns 5 + 6.

Line 1:- Identical with line 3 of column 4 of Table D.I-A,1.

Columns 5 and 6: Self-explanatory.

Column 7, Physicians' and Other Expenses, Total Expenses:

Sum of columns 9 + 11 + 13.

Line 1:- Identical with the sum of line 1 of column 7, Table D.I-A(2) and of Table D.I-A(3).

Column 8, Physicians' Surgical Services, Number of Claimants:

See preceding tables.

Columns 9 through 13: See preceding tables.

Column 14, Grand Total, Claimants Expenses:

Sum of columns 4 + 7.

Column 15, Grand Total, Benefits Paid by Plan:

See preceding tables.

TABLE D.III-A. PRIMARY CAUSE

This is an analysis of claimants, expenses, and benefits by primary cause for medical services.

Columns 2, 3, and 4 deal with all cases; columns 5 through 8 with hospitalized cases involving surgery; columns 9 through 12, hospitalized cases not involving surgery; and columns 13 through 15 with non-hospitalized cases.

Column 1, Primary Cause:

For each of the causes specified show data separately for: (1) all claimants, (2) male claimants, and (3) female claimants, as indicated in lines 2, 3, 5, 6, and the words "as above."

Line 1:- Sum of lines 2 + 3.

Line 4:- Sum of lines 5 + 6.

Column 2, Total All Claims, Number of Claimants:

The sum of columns 5 + 9 + 13.

Line 1:- The sum of lines 2 + 3. Also, identical with line 2, of column 2, Table D.I-A, 1.

Column 3, Total All Claims, Total Amount of Claimants' Expenses:

The sum of columns 7 + 11 + 14.

Line 1:- The sum of lines 2 + 3. Also, identical with line 1, of column 13, Table D.I-A, 1.

Column 5, Hospital Claims, Surgically Treated, Number of Claimants:

Number of claimants having hospital expenses in connection with surgical treatment.

Line 1:- The sum of lines 2 + 3. Also, identical with line 2, column 2, Table D.I-A,3.

Column 6, Hospital Claims, Surgically Treated, Aggregate Number of Days:

Number of days of hospitalization for cases involving surgery.

Line 1:- The sum of lines 2 + 3. Also, identical with line 2 of column 3 of Table D.I-A,3.

Column 7, Hospital Claims, Surgically Treated, Total Amount of Claimants' Expenses:

Amount of claimants' total expenses (hospitalization, surgery, other) in hospitalized cases involving surgery, for each of the causes specified in column 1.

Line 1:- The sum of lines 2 + 3. Also, identical with line 3, column 13 of Table D.I-A,3.

Column 8, Hospital Claims, Surgically Treated, Total Amount of Benefits Paid by Plan:

Total benefit amount for hospitalized cases involving surgery, for each of the causes specified in column 1.

Line 1:- The sum of lines 2 + 3. Also, identical with line 3, column 14 of Table D.I-A,3.

Columns 9 through 12, Hospital Claims for Non-surgically Treated Cases:

Similar to preceding columns 5 through 8 but for hospitalized cases not involving surgery.

Data corresponds to data in columns 2, 3, 13, and 14 of Table D.I-A,2.

Columns 13 through 15, All Other Claims:

Similar to preceding columns 9, 11, and 12, but for cases not involving hospitalization.

Data corresponds to columns 2, 13, and 14 of Table D.I-A,4.

TABLE D.III-B. SURGERY

This table analyzes services, expenses, and benefits for selected surgical procedures. It is patterned after Table D.II, but includes only surgical cases whether hospitalized or not.

As in Table D.III-A and as indicated in column 1, for each surgical procedure show the data for: (1) all claimants, (2) male claimants, and (3) female claimants.

Column 2, Number of Claimants:

Total number of persons receiving surgical treatment.

Line 1:- Sum of the lines 2 + 3. Also, identical with line 1, column 9, Table D.I-B.

Column 3, Hospitalization, Number of Days:

Line 1:- Identical with line 2, column 3, Table D.I-A,3.

Column 4, Hospitalization, Total Expenses:

Sum of columns 5 + 6.

Column 5, Hospitalization, Expenses for Room and Board:

Line 1:- Identical with line 3, column 5, Table D.I-A,3.

Column 6, Hospitalization, Other Expenses:

Line 1:- Identical with line 3, column 6, Table D.I-A,3.

Column 7, Physicians' and Other Expenses; Total Expenses:

Sum of columns 9 + 11 + 13.

Column 8, Physicians' Fees for Surgery, Number of Claimants:

Line 1:- Identical with line 1, column 9, Table D.I-B,1.

Column 9, Physicians' Fees for Surgery, Amount:

Line 1:- Identical with line 1 of column 10, Table D.I-B,1.

Column 10, Physicians' Fees for Non-surgical Services, Number of Claimants:

Number of Claimants receiving surgical treatment who also filed claims for physicians' non-surgical services.

Column 11, Physicians Fees for Non-surgical Services, Amount:

Self-explanatory.

Columns 12 and 13: Self-explanatory.

Column 14, Grand Total, Claimants' Expenses:

Sum of columns 4 + 7.

Column 15, Grand Total, Benefits Paid by Plan:

Total benefits for surgical cases.

TABLE D.IV. SIZE OF CLAIMANTS' EXPENSES

This is an analysis of the plan's experience in cases involving various amounts of expenses for medical care.

Column 1, Size of Claimants' Expenses:

Amount of claimants' total expenses. For each class interval show data for: (1) all claimants, (2) male claimants, and (3) female claimants.

Column 2, Total, All Claims, Number of Claimants:

Sum of Columns 5 + 8 + 11.

Column 3, Total, All Claims, Amount of Claimants' Expenses:

Sum of columns 6 + 9 + 12.

Column 4, Total, All Claims, Amount of Benefits Paid by Plan:

Sum of columns 7 + 10 + 13.

Columns 5, 6, and 7, Claims Involving Hospital Expenses, Surgically Treated: Number of Claimants, Total Expenses, Total Benefits:

Number of claimants hospitalized for surgical treatment who incurred total expenses of amounts specified in column 1, (i.e., Number with total expenses of $1 to $49, $50 to $99, etc.); their total expenses; and the total amount of benefits paid them by the plan.

Columns 8 through 10, Claims Involving Hospitalization, Not Surgically Treated:

Similar to preceding columns 5 through 7, but with respect to cases not involving surgery.

Columns 11 through 13, All Other Claims:

Similar to preceding columns 8 through 10, but with respect to all non-hospitalized cases.

TABLE D.V-A. MATERNITY SERVICES

This table deals only with maternity cases. It is in 2 parts: Duration, and Maternity Care. The same type of data is requested for each part.

In each of column 2 through 12 the entries for "total, all" under Duration should be identical with those for "total, all" under Maternity Care.

For Duration: This is the length of stay in the hospital in terms of "days" - 6 class intervals are shown.

For Maternity Care: This is the type of care provided.

Column 2, Number of Patients:

For Duration: This is the number of patients hospitalized for each of the lengths of stay shown in column 1.

For Maternity Care: This is the number of patients for each of the types of care shown in column 1.

Column 3, Hospitalization, Admissions:

The number of admissions to the hospital for (1) each of the different lengths of stay shown in column 1; and (2) each of the types of maternity care shown in column 1.

Column 4, Aggregate No. of Days:

The total days of hospital care received by patients for: (1) each duration of hospital stay; and (2) each type of maternity care.

Columns 5 and 6, Total Expenses and Total Benefits Paid:

The sum of columns 7 + 9 + 11; and columns 8 + 10 + 12, respectively.

Column 7, Hospital Expenses:

Amount of charges made to patient by the hospital or plan for that portion of the hospital bill in excess of the amount covered or provided by the plan.

Column 8, Hospital Expenses, Benefit Paid:

Amount paid by the plan toward the hospital bill for services to maternity patients.

Physicians' Fees - Columns 9 - 12

Column 9, Obstetrical Fees:

Amount of charges made to the patient by the physician for obstetrical services by physicians (excluding anesthesiologist) for that portion of his fee in excess of the amount covered or provided by plan.

Column 10, Obstetrical Benefits Paid:

Amount paid by plan toward charges for physician's obstetrical services.

Column 11, Anesthetist Fee:

Amount of charges made to the patient by the anesthetist (if not employed by or paid by hospital) for that portion of his fee in excess of the amount covered or provided by plan.

Column 12, Anesthestist Benefits:

Amount paid by plan towards charges for anesthestists' services.

TABLE D.V-B. MATERNITY SERVICES: STATE SUMMARY

This table together with Table D.I-B will furnish, State by State, the entire experience of the plan -- nonmaternity and maternity cases.

Carriers with one level of benefits will use only total lines, i.e., 1, 4, 5, etc. Those with 2 options will give data for both options combined on lines 1, 4, 5, etc; for high option on line 2 and the lines immediately below lines 4, 5, etc.; for low option on lines 3 and on the 2nd line following lines 4, 5, etc.

The data requested are identical with those requested on line 1, Table D.V-A, separately for all areas combined, and separately for each state and other geographical subdivision of the United States.